For Immediate Release:
Friday, December 20 2002
Contact:
Stephen P. McDonald
Utah Department of Health
Public Information Office
801-538-7099

NEWS RELEASE

Utah Rule Provides First Year of Patient Safety Data

(Salt Lake City, UT) - A first-year summary of Utah's patient safety initiative was released today by the Utah Department of Health (UDOH), Utah Hospitals and Health Systems Association (UHA), and HealthInsight. The UDOH's patient safety rules that took effect October 1, 2001, require hospitals and outpatient surgical centers to report adverse medical and drug events and to have programs to improve patient safety.

Utah is one of 20 states that require medical error reporting. "We see these rules as an important tool that allows Utah hospitals to share information in order to better identify problems and create solutions," said Rick Kinnersley, President, UHA.

"Medical errors happen in all healthcare settings and also at home," says Scott Williams, M.D., UDOH Deputy Director. "Medicine is complex and systems aren't always designed to minimize errors. But we now have a structured way to identify them, evaluate them, and try to learn from each event in order to prevent as many as we can."

The three organizations expect that with better awareness, recognition, documentation, and tracking, the rates of adverse events will initially increase for the first few years as data continues to be collected. "This doesn't mean that the incidence of errors will actually be going up – it means that they are now being reported and we have a system for improvement," says Williams. "By reporting these events we can begin to identify ways to eliminate errors and further improve delivery of care." Aggregate data analyzed at a state level helps identify trends that can benefit all facilities.

An adverse event or a medical error is defined as an injury resulting from a medical intervention – either an act of care or the omission of necessary care – rather than from the patients' underlying disease process. There are two kinds of adverse events that are currently reported under the Utah rules; adverse drug events (ADEs) and sentinel events.

- MORE -

Adverse Drug Events (ADE)

Definition: Not all ADEs result from errors nor are all preventable. Reportable ADEs include allergic reactions, adverse effects of drugs (such as nausea/vomiting or fever), drug-drug interactions, and errors of medication dose, type, route, or timing. A patient may have an ADE that leads to a hospital admission or may experience an ADE during the course of patient care in the hospital or surgical center. As required in the rule, all hospitals must have ADE reduction programs and these will be audited every three years.

Results Reported to UDOH: In a 12 month reporting period, 3.2 percent of nearly 240,000 inpatients experienced ADEs as reported by 41 acute care hospitals in Utah. "In the absence of a national reference, we will continue to track this number from year to year to see how it fluctuates as reporting improves and as ADE reduction programs are fully implemented," explains Williams. The data showed that the incidence of ADEs increased with the patient's age and length of stay in the healthcare facility. Analysis of data submitted by outpatient surgical centers is underway, but is not yet available. "This discharge data is being interpreted with caution, since the data does not separate events that occur before patients are admitted from those that happen in the hospital after admission," says Williams. He also noted the discharge data does not indicate the degree of harm to the patient, and does not always separate medical errors leading to ADEs from unanticipated patient reactions following the appropriate use of medications.

Anticoagulants (blood thinners) are one of the drug types more frequently associated with ADEs. These types of drugs are of interest to researchers and practitioners because they are administered in both inpatient and outpatient settings. Utah hospitals identified 415 adverse effects from this class of drugs.

Sentinel Events

Definition: A reportable sentinel event includes surgery on the wrong patient or the wrong body part, suicide of a patient, alleged assaults, or major loss of physical or mental function or death that is directly related to medical care provided to a patient and is not an expected outcome of the patient's underlying condition. UDOH's new reporting rule requires community hospitals; specialty hospitals, such as orthopedic and psychiatric hospitals; and ambulatory surgical centers to report all sentinel events by telephone and by written form. Following each sentinel event, facilities are required to conduct an internal "root cause analysis" to learn why the event occurred. An action plan is then submitted to UDOH outlining ways that the hospital or surgical center plans to prevent similar errors in the future through interventions such as staff education, closer staff supervision, process changes and better tracking procedures.

Results Reported to UDOH: Among nearly 450,000 inpatient hospital and outpatient surgical center discharges, 34 sentinel events were reported by 76 facilities during the one-year reporting period since the rule took effect. The 34 sentinel events (18 Male/16 Female) include 18 deaths, 10 individuals losing mental or physical function, five wrong-site or wrong-patient surgeries, and one patient suicide not related to clinical service. The medical/surgical units were the most common location of events in hospitals with 13 occurring there. Next were the intensive care unit and operating room with seven each, and the remaining seven cases occurred in other facility settings. At this time there is no national standard of reporting to provide a reference as to how these 34 sentinel cases compare to the rest of the U.S. Previous research, however, suggests that Utah's rate of serious sentinel events may be lower than other areas of the country. In other public health surveillance programs in Utah, such as influenza case monitoring, the number of identified cases often increase initially as tracking systems improve.

Utah's new patient safety reporting system now provides an opportunity for providers to work collaboratively and find solutions to these complex issues. In an effort to refine the reporting system, UHA has formed two "user groups" consisting of hospital, public health, and quality improvement representatives– one for sentinel events, and one for adverse drug events. The ADE group is developing a standard tool for hospitals to improve detection of ADEs, and the sentinel event group is working to improve root cause analysis processes across the state.

"Utah's hospitals work very hard to provide quality patient care in their communities," commented Kinnersley. "The vast majority of patients treated in our hospitals have successful outcomes and an improved quality of life. As in any large complicated system, however, errors do occur occasionally, and Utah's hospitals are committed to making their facilities as safe as possible."

Because of its importance, the administration of the patient safety program at the UDOH has been absorbed into the UDOH's Division of Health Systems Improvement and the Office of Health Care Statistics without additional state funding. Utah was later awarded a three-year (2001-2004) demonstration project grant by the federal Agency for Healthcare Research and Quality. The funding will help Utah study the use of existing hospital discharge data in tracking and reducing medical adverse events in hospitals.

Heeding the Institute of Medicine's recommendations (1999) of a nationwide mandatory reporting system, the grant makes use of diagnosis codes in the discharge data already reported by hospitals. This avoids imposing additional reporting burdens on hospitals and also makes use of a well-standardized and widely used system. Researchers, funded by the grant, are examining the value and limitations of this hospital discharge data. UDOH hopes to generate specific recommendations that can improve the data's usefulness.

- MORE -

National research has also established the important role patients and families play as partners in helping the medical care system identify and prevent errors. Patients should ask questions when treatment seems different than they expected and family members can help patients to take the right medications at the right time, and better enable their loved ones to follow physician advice, especially after returning home.

# # #